

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021793

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5537

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Homer G. Phillips

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)
4561 St. Louis

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

Shedrick

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Shedrick

Kellum

5

21

63

5. SEX

Male

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Oct 15 1895 67

9. AGE (last birthday)

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labore

10b. KIND OF BUSINESS OR INDUSTRY

Wholesale

11. BIRTHPLACE (City and state or country)

Tenn

12. CITIZEN OF WHAT COUNTRY

U.S.A

13a. FATHER'S NAME

James Kellum

13b. MOTHER'S MAIDEN NAME

Fannie?

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)

No

NO.

908

17. INFORMANT

Fannie Mae Sharp 4524 1/2 N. 1st St. St. Louis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH
Undet.

DUE TO (b)

Cerebrovascular Accident

DUE TO (c)

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: (a)

331X

PART III. If deceased was female was there a pregnancy in last 90 days:

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 5-19-63 to 5-21-63 and last saw him alive on 5-21-63

Death occurred at 2:35 A. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

J. H. Utley MD

22b. ADDRESS

2601 N. Whittier

22c. DATE SIGNED

5-22-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

5-25-63

23c. NAME OF CEMETERY OR CREMATORY

Grassland

23d. LOCATION (City, town, or county)

Tenn. Madison Tenn

24. FUNERAL DIRECTOR

ADDRESS

2769 Chateau

25. DATE RECD. BY LOCAL REG.

MAY 24 1963

26. REGISTRAR'S SIGNATURE

Earl Smith M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

1

2

3

4

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2/10/63

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1

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77-0

77

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.